CIRCULAR NUMBER 3

MEDICAL SECTION

GHQ FEC

1 March 1947

Articles for Publication in Circular

It is desired that the Monthly Circular Letter published by the Medical Section, GHQ, FEC, be of maximum value to all of the Medical Department personnel in the field. To that end, articles of professional or administrative nature that might be of general interest are needed. All Medical Department officers as well as the Commanding Officers of Medical Department units and the Surgeons of the major commands are solicited for articles of administrative or technical value. Such articles should be forwarded so as to reach the Medical Section, FEC, not later than the 20th of the month preceding the publication of the circular in which it is to appear.

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

CIRCULAR LETTER)
:
NO . . . . . .3)

APO 500
1 March 1947

PART I

SUBJECT ADMINISTRATIVE SECTION

I. Organization of the Medical Section

1. The following is a list of commissioned personnel currently assigned or attached to the Medical Section:

Brig. General James A. Bethea	Surgeon
Colonel John C. Fitzpatrick	Deputy Surgeon
Major Frederick H. Gibbs	Executive Officer

ADMINISTRATIVE BRANCH

Major Frederick H. Gibbs	Chief
Lt. Edwin W. Payne	Assistant

PLANS AND OPERATIONS DIVISION

Colonel John C. Fitzpatrick	Director
Major Frederick H. Gibbs	Deputy Director
Major John V. Painter	Chief, Supply and Fiscal Branch
Captain Felix G. Rajecki	Chief, Plans & Operations Branch
Captain Glorio J. Patsy	Plans and Operations Branch
Captain Robert E. Watson	Plans and Operations Branch
Lt. T. J. Shelton	Plans and Operations Branch

PERSONNEL DIVISION

Lt. Colonel Lewis S. Shellenberger	Director
Major Sam A. Plemmons	Deputy Director
Captain Joseph W. Jacobs	Chief, Analysis Branch

CONSULTANTS

Colonel Charles K. Berle	Medical Consultant
Colonel Terry P. Bull	Dental Consultant
Colonel Stanley C. Smock	Veterinary Consultant
Lt. Colonel Warner F. Bowers	Surgical Consultant
Lt. Colonel Ruby F. Bryant	Nursing Consultant

II. Redesignation of the Chief Surgeon's Office

2. Attention is invited to paragraph 2, Circular No. 14, General Headquarters, Far East Command, 31 January 1947, Subject: "Current Organization of General Headquarters, Far East Command." The Chief Surgeon's Office is redesignated Medical Section, and the Chief Surgeon is redesignated Surgeon.

III. Construction Policy

3. Many of the hospitals of this command have found it necessary to secure additional construction to make the hospital plant suitable for the treatment and hospitalization of patients and for the housing of the duty personnel. It is believed that first priority should be given to providing minimum comforts and facilities for patients before the rebuilding of quarters or provision of recreational comforts for duty personnel.

IV. Reporting of Births

4. Surgeons of all hospitals where children are born to military personnel should advise the parents that the Army-Navy Journal and the Army-Navy Register will be glad to publish a notice on the birth of the child if the proper information is forwarded to this publication by the parents concerned.

5. Such information should be sent to The Editor, Army-Navy Journal, 1711 Connecticut Avenue N.W., Washington, D.C., and to The Editor, Army-Navy Register, 511 11th Street, N.W., Washington 4, D.C., and should include the date and place of birth, sex of child, and name and rank of parents.

V. Medical Attention and Hospitalization for Foreign National Employees Paid from the Occupation Costs

6. Attention is invited to the provisions of AFPAC Regulation 50-20 dated 15 August 1946 and the references listed thereon, which name

the classes of individuals authorized medical attention or hospitalization in United States hospitals. Foreign national personnel paid from the costs of occupation are not authorized by this regulation to receive either treatment or hospitalization in United States Army hospitals, except as an emergency measure to prevent undue suffering or loss of life or limb.

VI. Recent War Department Publications

7. Attention is invited to War Department Memorandum No. 600-900-2, 31 January 1947, subject: Venereal Disease Control Council.

VII. Report of Medical Department Personnel

8. Reference is made to Section II, War Department Circular 3, 1947, concerning monthly reports of Medical Department personnel.

9. Above-cited directive requires revision of the instructions contained in AFPAC Circular 49, 7 June 1946, as amended by Section I, AFPAC Circular 91, 1 October 1946, concerning preparation of subject report by medical units and installations in this theater.

10. A new Far East Command directive has been prepared and will be submitted to G-1, General Headquarters, Far East Command, for approval and release upon receipt of the 1 November 1946 revision of WD AGO Form 8-19. Pending issuance of this directive reports should continue to be submitted as required by directives cited in paragraph 8 above.

VIII. Annual Reevaluation of Medical Corps Officers

11. The annual reevaluation of Medical Corps Officers classification is progressing satisfactorily. In general, the evaluation forms have been thoughtfully prepared.

12. The most frequent inconsistency in preparing the reevaluation form WD AGO 178-3 has been in regard to an estimated high competency with a concurrent recommendation for a D rating. Some officers recommended for "D" were estimated to be competent to be chiefs of services or sections for their specialty in hospitals of 250-1500 beds. The reevaluation prototype for "C" requires an officer to be capable of being chief of a service or section in his specialty in a 250 bed hospital.

13. Very few officers currently classified as a "D" grade specialist will be elevated to a "C" rating, since their training and experience would not merit it. A few of those officers having approximately 18 months residency after internship, and who have discharged professional responsibilities in an outstanding manner will be elevated from "D" to "C".

IX. A Resume of Complaints of Hospital Operations

14. The following resume of complaints concerning hospital management comes from the Office of The Surgeon General. It is worthy of the

study of every hospital commander. It is planned to publish such complaints from time to time as they are received from various sources so that our hospital administration may be able to avoid such criticism.

"1. It is realized that all commanding officers of hospitals are interested in increasing the efficiency of operations of their installation and that each one is desirous of reducing to a minimum complaints received from any source. A number of commanding officers have expressed a desire for information concerning the more common type of complaints that are received in The Surgeon General's Office from individuals and organizations which criticize or imply that some particular hospital is not performing its mission in a satisfactory manner. A review of the complaints and causes for correspondence relative to the management of hospitals has been made and the following discussion is a resume of those more frequently encountered. This list has been prepared from correspondence received from individual patients, congressmen, residents of the locality in which the hospital is located, veterans organizations and perusal of reports received in this office following inspections made by higher authority, representatives of The Surgeon General's Office and various consultants. This resume is merely submitted for the information and study by all concerned.

"2. Indifference or carelessness on the part of personnel in charge of information offices at Army Hospitals is frequently noted, particularly after 4:00 or 5:00 P.M. Many hospitals "go dead" at 4:30 P.M. and do not become revitalized until 8:30 the following morning. Even the Officer of the Day personnel are frequently difficult to locate during these hours.

"3. Too frequently the commanding officer and the executive officer will be noted spending the major part of the day at their desks. It is believed the commanding officer and the executive officer should conduct their offices so that one or the other is purposefully visiting the various sections of the hospital during regular hours of duty, and frequently after regular duty hours.

"4. Hospital commanders and executives frequently acquire a habit of failing to note signs which should invite their attention toward needed corrections. Disorder in or about professional offices and dressing rooms, which is permissable in a measure during work hours, often gradually increases and closets and other out of the way corners and passages are too infrequently examined, with the result that they become catchalls for all sorts of seldom or never used items of equipment and supplies.

"5. Indications of waste are ignored.

"6. It has been reported that visits to the patients in the wards and a reasonable check of the attitude of ward surgeons towards their patients is not made. Ward nurses and ward surgeons should be questioned upon each occasion the ward is visited by the Commanding Officer

or executive, with particular reference to any critical case - any case in which progress is not as anticipated and any case of prolonged stay, - and for complaints by the patients in the ward, either with reference to their treatment at a hospital far distant from their homes, or any other reason.

"7. The commanding officer should frequently visit the officer chiefs of services and discuss and review all major problems with them. He should continuously stimulate the interest of the professional services in establishing the case of each patient at the earliest practicable date a decision whether the patient can be reconditioned (salvaged) and returned to duty or will be discharged on CDD.

"8. Chiefs of services should be continually alert that ward surgeons in preparing clinical records carefully question patients, particularly commissioned officer patients where retirements proceedings are anticipated, so that answers will be full and complete and not ambiguously expressed. Instances have occured where officer patients have been hospitalized for the purpose of observation and treatment prior to retirement for a diagnosed condition such as diabetes mellitus wherein the disposition board would find "no," the retirement board would reverse the latter, and even upon return review ordered by the War Department, the record has not been completed in a manner to support the finding despite the fact that nowhere in the record of the case were pertinent questions intelligently asked or answered. In one instance an officer was retired after six months of duty for diabetes mellitus in LOD because there was no evidence in the ward that he had ever suffered from diabetes prior to his entry into the service, and upon his negative answer to the question, "Have you any knowledge that you had diabetes prior to coming into the service?" during his period of hospitalization, and despite the fact that this officer, who had been hospitalized for a specific purpose for three months and had been before four boards which had reversed each other, had never been asked the question, "Do you have knowledge that you ever had sugar in your urine prior to being ordered to active duty in this emergency?" He had answered upon later investigation that he had full knowledge of having sugar in his urine and had been treated for that condition for a year prior to coming into the service. Examples of need for careful questioning on the part of ward surgeons, chiefs of services, and board members can be exhibited at length.

"9. Commanding officers, chiefs of services and others responsible, frequently visit wards and come away with the impression that all is well, when in fact there may be a case in the ward which has been progressing unsatisfactorily for days, has not been reported, and is not invited to the attention of the chief of service or commanding officer on their visits to the ward. An example of this type may be cited in a case of simple hemorrhoidectomy on a young and otherwise well and strong soldier, wherein a pelvic cellulitis developed and was treated by Sitz baths and codein for pain, and the patient was up and about the ward for six days. Upon becoming critically ill on the evening of the sixth day, consultation was

requested, morphine and sulfonamides were administered, the patient was taken to the operating table the following morning, gas anesthetic was applied and the patient died before leaving the operating table. It was certified upon investigation of death in this case that the chief and the assistant chief of the surgical service had visited this ward on several occasions subsequent to the primary operation which had been performed by the ward surgeon (an interne); however, this case was ignored or given but cursory attention by the officers in charge of the surgical service because no comment was made regarding the complications and unfavorable progress. The hospital commanding officer maintained the attitude that all responsibilities had been met because the chief and assistant chief of the surgical service had visited the ward during this interval. This case served also as an example of an instance wherein the chaplain had not been notified of the seriousness of the case; also, as an example of failure to notify the parents or nearest relative by telegram. The telegram sent relative to the seriousness of this case was sent at such a late hour that it was not received until some considerable time after the death of the soldier. The above example and many more could be cited as evidence of lack of comprehension of the alertness and meticulous attention to detail which is required to satisfactorily administer a hospital or a special service within a hospital.

"10. It has been said that some hospital commanders because of heavy administrative loads have not been able to follow in detail current professional trends. This fact, however, should necessitate alertness on the part of the hospital commander and should stimulate him to closely observe and intelligently question the actions of those in whom professional confidence is reposed. Only by such close observation and personal knowledge can the Commanding Officer be assured that the various boards are functioning properly.

"11. An intimate knowledge by the commanding officers in many hospitals of the detailed accomplishment of the dental service is frequently absent. An efficient hospital commanding officer can and should be in possession of the actual facts regarding the quality and quantity of the work of the dental service.

"12. Practically all clerical work can be accomplished in a dental office oy clerks, thus freeing the time of the chief of dental service for professional occupation, consisting of examining patients and supervising the work of the dental operators and hygienists.

"13. It is considered desirable that hospital commanders take at least one meal per day in one of the hospital messes. An occasional evening meal in the enlisted patient's mess or detachment mess frequently will be of great value in determining the quality of the mess. From reports received the above practice has apparently been overlooked at some hospitals.

"14. It has been reported that personnel shifts are frequently not made promptly or effectively by hospital Commanding Officers to meet altered requirements. Personnel management responsibility is often split between military and civilian directors rather than have both under one director of personnel.

"15. Hospital commanders in some instances have not given sufficient attention to working conditions for civilian employees and only occasionally is there a well defined means by which complaints may come to the attention of the hospital commanders.

"16. From some reports it appears that hospital commanders may frequently be unaware of the existence of small but well developed and powerful cliques within the civilian as well as the military staff of the hospital both officer and enlisted.....The inevitable result is an "unhappy" hospital. It has been frequently observed that the commanding officer has a major responsibility in the development of this extremely undesirable condition by unthinkingly limiting his association to a few officers of his staff.

"17. Many commanding officers of general hospitals that are located at some distance from other military installations or large cities are either completely unaware of or entirely oblivious to the problem of poor nurse morale and its adverse effect on patient morale and care. This has occasionally been made worse by the attitude of a few chief nurses who persist in thinking of nurses in terms of undergraduates in training rather than officers in the Army. Midvictorian rules for the purpose of curbing one or two offenders in large groups are unnecessary and unwarranted and should not be tolerated by the commanding officer. The offenders should be disciplined rather than the group. The commanding officer should arrange a well planned social-recreational schedule for all officers and their guests in his command attractive enough that all will attend voluntarily. The effectiveness and value of an officers club in a command can be estimated by the attendance of officers and nurses during their off duty hours. This should be carefully observed and studied by hospital commanding officers.

"18. It has been recommended that commanding officers of hospitals should visit neighboring medical installations frequently. In those service commands where service commanders authorize hospital commanders to visit other outstanding hospitals such visits are found to be beneficial to all concerned....."

15. In similar vein, inquiries from patients have reached the Surgeon, GHQ, FEC, concerning requests for evacuation to the Zone of the Interior for treatment that a dispensary or ward officer has indicated as desirable, but only available in the United States. If such advice is given to a patient it should be given by a competent specialist, and the situation should be fully explained to the patient. Any patient suffering pain should not be returned to duty by a dispensary surgeon with such advice, but instead the patient should receive the benefit of further observation and treatment in larger medical installations where adequate specialists are assigned.

X. Records and Reports of Sick and Wounded

16. In the past month numerous individual medical records from all types of medical installations have been returned by The Surgeon General

to the preparing unit for correction. Attention is invited to Section III, AR 40-1025 and TB MED 203 concerning the preparation of these records. To eliminate repeated errors each item of the record should be checked separately against the above cited regulations.

17. Attached as Appendix I is a list of errors that occur in the preparation of individual medical records.

XI. Medical Department Technical Maintenance

18. Proper maintenance of technical equipment is necessary if optimum service is to be obtained from this equipment in medical installations. Replacement of technical equipment in this theater is limited due to the transportation difficulties, and every effort should be made by those concerned to increase the service expectancy of this equipment by exercising all possible care in its maintenance.

19. The following suggestions and comments are made for the information and guidance of responsible officers.

a. Maintenance and Use of Electrical Equipment:

(1) The power situation in this theater is a major cause of equipment failure. In areas where the current is 50 cycle, 100-200 volt AC, this lowered voltage has caused burned-out motors and transformers in American equipment with 60 cycle, 110-220 volt AC motors. Fluctuating current and dropping voltage have caused damage to x-ray and therapeutic equipment. In areas where current fluctuates and voltage is low, it is necessary to put x-ray and therapeutic equipment on independent leads with nothing whatsoever on the same line. This will increase the life service and efficiency of all units in operation.

(2) A bi-weekly or weekly cleaning of exposed parts on x-ray machines and a weekly blowing-out of dust by means of a tire pump or bellows through diathermy equipment will not only increase the length of service, but will lessen the possibility of poor contacts and electrical failure.

b. Servicing of Surgical Equipment:

(1) Due to the amount of foreign material, iron, and alkali in the water supply of this theater, great care should be exercised in servicing sterilizers and autoclaves. All gauges and valves should be removed and checked at least once every two months. Openings should be thoroughly scraped and cleaned; pipes flushed out. It should be noted in this connection, that proper tools for this work will prevent possibility of ruined couplings and joints.

(2) The same care should be taken in cleaning the pump and oiling the suction apparatus in surgery or EENT clinics. Motors should have one drop of oil in each oil cup once each month. This should be carefully checked to prevent burned-out motors.

c. Maintenance of Electro-Cardiographs:

(1) The Electro-Cardiograph is one of the most delicate machines used in medical installations. For this reason, extreme caution must be used in handling, and it should be moved, after once being installed, only in cases of emergency. Very little repair work can be done on EKGs by personnel of the medical installation; it is usually advisable for a trained maintenance man to accomplish repairs. In the event the unit must be sent to a Medical Supply Depot for repairs, the greatest care should be taken in packing it, and at least 12 inches of insulation are needed to insure safe delivery.

XII. Volunteers Needed for Short Professional Training

20. Medical Corps officers who have a real interest in radiology or in eye, ear, nose and throat work, and who have at least eight months service expectancy in this theater may submit a letter to the Commanding General of the Major Subordinate Command (Attn: Surgeon) requesting an assignment where practical training in these subjects can be given.

21. Several officers will be afforded this training opportunity and those adjudged to have sufficient aptitude and accomplishment will then be assigned in an area where their services in the specialty will be utilized. Such officers may expect to be classified as a "D" grade specialist.

22. In computing the service expectancy in the theater, an officer should consider eligibility under current readjustment regulations. The number of Medical Corps Officers being declared surplus has dropped to almost nil, so training, subsequent assignment, and classification as a "D" specialist would in no way lengthen the overseas tour or the total service required.

PART II

TECHNICAL

XIII. Certain Precautions to be Taken in the Treatment of Amebiasis With Emetine Hydrochloride

The presence of amoebic infestation in various military and civilian personnel in the Far East Command in different degrees of severity and at different seasons of the year, would seem to justify a consideration of the precautions to be taken and the signs of untoward effect of one of the most useful drugs used in the treatment of this condition.

According to information published by The Surgeon General's Office, there are three important drugs used as therapeutic agents in the treatment of amebiasis: emetine, carbarsone and diodoquin. These remarks are concerned with the first of these drugs, emetine. There exists in the minds of some members of the medical profession a belief that emetine is a drug of considerable toxicity and should be used only when symptoms are severe or when other agents do not suffice. Emetine does have potential toxic properties, but when administered properly and with certain precautions, may be given with more than a fair degree of assurance of safety. Emetine should be given to all patients who have active symptoms of amoebic infestation except in certain selected cases. It should not be given to patients who have had or have at present evidences of definite cardiac disease, unless this condition is carefully evaluated before treatment is begun. History or evidence of past myocardial infarctions, conduction defects and marked hypotension are possible contra-indications. It should not be denied to any patient who is actually ill with hepatic abscess, amoebic hepatitis, or other acute lesions, unless a definite contra-indication is discovered. Emetine may exert a toxic effect upon the neurological and cardio vascular systems when given improperly, or without the necessary precautions. The patient under emetine therapy should be at absolute bed rest during medication and for several days following. Activity should be resumed gradually. Emetine exerts its best effects when the patient is on a diet with little residue. Liquid or very soft diet is desirable. Repeat courses should not be given for at least two weeks.

An electrocardiogram to be used as a control or pattern should be taken before treatment is started. This should be repeated every third day and especially before permitting patient to exercise following therapy. The changes which might be considered as evidence of toxic

effects of the drug are those of conduction defects, namely prolongation of the PR and QRS intervals. There may be also changes in the T-waves in one or more of the three classical leads. These changes consist in diminution in amplitude to flattening or T-wave inversion. When present, these changes should cause prompt consideration as to the advisability of discontinuing the drug or of reducing the dosage.

It is to be noted that any E.K.G. changes observed, usually without exception, disappear soon after the drug is discontinued, but they offer an excellent guide for determining the future activity of the patient. There may also be subjective symptoms of a peripheral neuritis, but again this condition is transitory and usually calls for no additional medications. Other symptoms indicating toxic effects of the drug are weakness associated with hypotension, nausea and general malaise. No effort has been made here to discuss other remedial agents in the treatment of amoebic infection. It may be well to state that emetine with the above precautions may be used in certain hepatic conditions where carbarsone is contraindicated.

The dosage of emetine is well known, and for reference is available in the various informative bulletins published by the Office of the Surgeon General. In estimating the dosage of emetine due consideration should be given to body weight. The average adult dose is from Gr $\frac{1}{2}$ to Gr 1 by hypo for from six to eight days. Some authorities advocate a 6 day limit.

This brief outline is not intended to discourage the use of one of the most valuable drugs in the treatment of amoebic infection, but on the contrary to emphasize the fact that the drug may be used effectively and safely when indicated.

XIV. Inspection of Subsistence Supplies, Canned Foods

General: The provisions of Army Regulations 40-205 prescribe that canned foods which have an abnormal odor, taste, or appearance will not be served as food.

Cans having a normal external appearance usually contain a sound product. The most evident criterion of spoilage is the absence of flat ends. Round cans should have ends that are flat or slightly concave. Paneling is not evident except in larger sizes. Rectangular cans should have flat ends and well drawn in sides.

Some types of spoilage cannot be detected from the appearance of the unopened can. One type is the "flat sour" where bacterial growth develops a certain amount of lactic acid which makes the product taste sour but does not develop any gas.

When food is undergoing decomposition, spoilage is readily apparent by examining the appearance of the can. The can is usually a "sweller". The taste and odor of the product will reveal advanced

decomposition. However, no food that is abnormal in appearance or odor should be eaten or even tasted since the above spoilage signs are also characteristic for cans in which patogenic micro-organisms are present.

The following criteria for the disposition of defective cans of food pertains only to canned foods that were relatively sterile (commercially sterile) at the time of canning. Items of food that have been cured or processed by methods other than sterilization, and/or where the can is used for protection only should not be inspected under standards set up for relatively sterile products. These items include such foods as dried fruits and vegetables, powdered eggs and milk, dried beef, bacon, dehydrated vegetables and soups, flour, cornmeal, salt, sugar, rice, cereals, spices, candy, cocoa, chocolate, tea, coffee, biscuits and baking powder.

Inspection Criterion:

a. Leaky Cans. Cans with leaky seams or with pin-hole leaks should not be issued but be recommended for condemnation.

b. Rusted Cans. Rust is the cause of considerable loss in canned foods in the Pacific Area. Exposure to rain, salt spray, and sweating, favors the development of rust. Inadequately ventilated storage such as may be found when canned goods are stored under tarpaulins, lends to rusting and markedly increases the rate of deterioration.

Slightly rusted cans (rust covering not more than 1/10 of the surface), if normal otherwise, may be recommended for shipment or issue.

Moderately rusted cans (surface rust without perforation), if otherwise normal, may be issued but shipment or storage should not be recommended.

Severely rusted cans (more than 1/2 the surface covered or where the rust has penetrated deeply into the metal, or in instances where the rust has definitely weakened the can), should be considered as unfit for issue.

c. Swelled Cans. The swelling of a can is the chief external indication of a deteriorated product. Although some swellers may contain food that is fit for consumption it is a good rule to reject all cans that show signs of swelling.

Springers and flippers. A springer may be a potential bacterial or chemical sweller. Springers should not ordinarily be used as food. Cognizance should be taken of the fact that under different temperature conditions a flipper may become a springer and a springer may become a sweller. In instances where a large per cent of flippers or springers are found in a given lot of canned foods representative samples should be submitted to a Medical Department Laboratory for examination, prior to making a recommendation as to disposition.

d. Dented Cans. Badly dented cans of meat, meat food products, vegetables, fish and milk should not be issued. A badly dented can is one that is sufficiently dented to cause bulging of both ends and/or the side or end seams damaged sufficiently to weaken it. Such cans readily spring leaks and may damage other cans in the same case.

Moderately or slightly dented cans showing no seam damage may be passed for issue or shipment if otherwise normal.

Storage Life of Canned Foods:

The life of canned foods in storage depends upon many factors such as the nature of the product, type of can, processing method, and above all, on the temperature of storage. In general, deterioration doubles for each 18 degrees Fahrenheit rise in temperature of storage. Thus, the greatest precautions are required to avoid high temperatures and exposure to sun. The coolest place available should be used for the most perishable products such as yeast, dried egg powder, dried cut fruits, evaporated milk, and canned juices. Canned meats and meat food products may be stored for a period of three years at a temperature ranging from 70° to 100° Fahrenheit under proper warehousing conditions. A loss of thirty to thirty-five per cent may be expected in some canned foods after a storage period of five years.

XV. Venereal Disease Lectures

The following letter from the Surgeon, Far East Air Forces, to the Surgeon, Thirteenth Air Force, is quoted for your information:

"I have recently taken occasion to listen to some V.D. lectures given by medical officers. The talks were so different from what I expected from previous experience that I believe it of paramount importance that you and your staff make it a matter of high priority to also actually listen to some of these talks if you have not already done so.

"If the ones I have listed to are generally representative of those all over it is apparent that there is an enormous amount of room for improvement. I feel sure that some medical officers are doubtless doing extremely well but I believe you will find as I have, that the talks are often characterized by lack of preparation, a very poor monotonous fumbling delivery and complete failure generally to apply those well known principles of giving training lectures. The lack of imagination and the extremely poor use of training aids further characterized them. They are being given in many cases by the most junior medical officer.

"The effect of some of these lectures can easily be of negative value and surely results in a marked lowering of the prestige of the Medical Department in the minds of the enlisted men; all this at a time when we are particularly in need of a most effective discussion on the subject with military personnel generally.

"Let me suggest that our medical officers giving these talks review the principles of training and apply them insofar as is practical. Further, that they be mindful of their extreme importance from many standpoints. Let me also suggest that the talks be given first before a small group of officers for constructive suggestions and criticism prior to being presented to the enlisted men. They must all be most carefully planned out in detail in advance and under no circumstances show evidence of lack of thoughtful preparation or poor taste.

"I believe that these lectures on V.D. should be a real contribution in each instance and should represent the best that each medical officer is capable of giving.

"It would be to everyone's advantage to go all out on this proposition. This is a matter I hope we can get corrected before the Medical Department is subject to criticism."

PART III

STATISTICAL

XIV. Evacuation

1. During the period 28 December, 1946 to 31 January, 1947, the following patients were evacuated from the several major commands:

	AIR	WATER	TOTAL
JAPAN	116	376	492
MARBO	37	21	58
PHILRYCOM	60	290	350
KOREA	124	80	304

2. The following are the evacuations per 1000 strength for the period 28 December, 1946 to 31 January, 1947:

JAPAN	3.7
KOREA	5.1
MARBO	3.8
PHILRYCOM	3.8
THEATER	4.0

3. As of 31 January, 1947, the following number of patients were awaiting evacuation:

JAPAN	264
MARBO	25
PHILRYCOM	54
KOREA	73

XV. Hospitalization

1. The Bed Status Report as of 31 January, 1947, is as follows:

	Total T/O Beds Present	Total T/O Beds Established	Total T/O Beds Occupied
JAPAN	4950	4950	4082
MARBO	525	525	228
PHILRYCOM	4270	3726	2515
KOREA	2100	1656	1447
Total	11,845	10,857	8,272

2. The number of authorized beds, percent of authorized beds occupied, percent of operating beds occupied for the period ending 31 January 1947, are as follows:

	Beds Authorized	% Authorized Beds Occupied	% Operating Beds Occupied
JAPAN	5,229	78	82
KOREA	2,108	68	78
MARBO	607	37	43
PHILRYCOM	3,394	74	67
THEATER	11,184	74	76

3. Tables showing various admission rates are listed below:

ADMISSION RATES PER 1000 PER ANNUM

All Causes

Week Ending	THEATER	MARBO	PHILRYCOM	JAPAN	KOREA
3 Jan 47	863	398	573	1138	888
10 Jan 47	1066	381	763	1339	1130
17 Jan 47	1166	271	778	1486	1283
24 Jan 47	1201	263	744	1396	1654
31 Jan 47	1143	294	704	1426	1312

Disease

3 Jan 47	785	319	510	1060	783
10 Jan 47	993	291	702	1263	1049
17 Jan 47	1090	220	716	1410	1178
24 Jan 47	1144	190	698	1334	1601
31 Jan 47	1085	223	652	1363	1262

Injury

3 Jan 47	78	79	63	78	104
10 Jan 47	73	90	61	76	81
17 Jan 47	76	51	62	75	105
24 Jan 47	57	73	46	62	53
31 Jan 47	58	71	52	63	50

Psychiatric

3 Jan 47	18	27	6.1	27	18
10 Jan 47	23	7	17	21	38
17 Jan 47	14	6	7	14	26
24 Jan 47	10	0	5	18	4.1
31 Jan 47	8	7	2.3	9	13

ADMISSION RATES PER 1000 PER ANNUM

Organic Neurological Disease

Week Ending	Theater	MARBO	PHILRYCOM	JAPAN	KOREA
3 Jan 47	.5	0	0	1.3	0
10 Jan 47	.7	0	.5	1.2	0
17 Jan 47	.2	0	.6	0	0
24 Jan 47	.6	0	2.3	0	0
31 Jan 47	.3	0	.6	.3	0

Common Respiratory Disease

3 Jan 47	173	14	51	276	199
10 Jan 47	267	0	78	402	346
17 Jan 47	324	0	73	493	414
24 Jan 47	357	6	88	461	595
31 Jan 47	387	42	87	485	670

Influenza

3 Jan 47	17	0	0	40	0
10 Jan 47	27	0	0	61	4.7
17 Jan 47	40	0	1	85	7.9
24 Jan 47	45	0	0	49	113
31 Jan 47	34	0	0	41	76

Primary Atypical Pneumonia

3 Jan 47	18	3.4	10	26	19
10 Jan 47	16	3.5	4.5	18	37
17 Jan 47	17	0	6	20	32
24 Jan 47	22	3.3	8	25	40
31 Jan 47	20	.7	6	21	43

Common Diarrbea

3 Jan 47	10	0	16	3.9	16
10 Jan 47	10	0	9	3.7	28
17 Jan 47	7	0	8	2.7	19
24 Jan 47	11	6	9	11.0	16
31 Jan 47	5	0	6	2.1	9

Bacillary Dysentery

3 Jan 47	2.4	34	1.6	0	0
10 Jan 47	2.0	0	5	.4	.9
17 Jan 47	1.4	3.2	2.9	0	1.7
24 Jan 47	.5	3.3	1.6	0	0
31 Jan 47	1.1	0	2.9	.3	.8

ADMISSION RATES PER 1000 PER ANNUM

Amebic Dysentery

Week Ending	THEATER	MARBO	PHILRYCOM	JAPAN	KOREA
3 Jan 47	3.7	0	11	0	0
10 Jan 47	7	0	20	.4	.9
17 Jan 47	3.1	0	10	0	0
24 Jan 47	3.5	0	10	.3	1.6
31 Jan 47	5	0	14	2.1	.8

Malaria

3 Jan 47	18	7	40	1.7	3.7
10 Jan 47	20	7	56	3.3	1.9
17 Jan 47	15	3.2	48	1.6	.9
24 Jan 47	14	10	40	2.6	3.3
31 Jan 47	18	0	38	1.4	1.6

Infectious Hepatitis

3 Jan 47	2.7	0	1.6	1.7	7.5
10 Jan 47	2.3	3.5	3.4	2.0	.9
17 Jan 47	1.0	0	.6	1.9	0
24 Jan 47	3.5	0	1.7	5.5	2.5
31 Jan 47	1.8	0	2.3	1.4	2.4

Mycotic Dermatoses

3 Jan 47	7.2	27	11	4.8	0
10 Jan 47	6	21	5	6.6	0
17 Jan 47	4.2	3.2	5.2	5.5	0
24 Jan 47	4.0	6	3.5	5.9	0
31 Jan 47	4.6	0	6.3	6.0	0

Venereal Disease

3 Jan 47	114	7	123	137	76
10 Jan 47	144	3.5	179	162	86
17 Jan 47	130	10	149	152	83
24 Jan 47	108	3.3	120	134	59
31 Jan 47	115	3.5	115	144	70

APPENDIX I

Errors in the Preparation of Individual Medical Records

A list of errors that occur in the preparation of Individual Medical Records is published below for the information and guidance of all concerned. Regulations governing the preparation of these records are AR 40-1025, 13 December 1944, and TB MED 203, 19 October 1945. The paragraph numbers listed parenthetically after certain of the errors are references to AR 40-1025 except where otherwise stated.

1. The entry for the following item has been omitted:

   a. Separate entry for arm or service (par 42a)
   b. Organization to which assigned or attached (par 42a)
   c. Information on flying status for AAF personnel (par 42b)
   d. Type of specialized treatment given patient (SGO Circular 45, 1946)
   e. Anesthetic used for operation (par 28, TB MED 203)
   f. Disposition (par 66)
   g. Reference to Army Regulations under which patient was discharged (par 66e(1))
   h. The grade of the officer who signed the records (par 150b).

2. The following unauthorized entry should not be shown:

   a. Citation of special orders issued to effect admission or disposition
   b. The entry "formal" or "informal" in connection with a transfer
   c. The entry "unassigned detachment of patients".

3. Army serial number has not been properly recorded. It should be recorded as provided in C2, par 40, AR 40-1025, the digits grouped and preceded by the letter or letters when these are included in the serial number, thus: O- 543 264; 33 372 779; or R-1 257.

4. The entry for arm or service has not been recorded separately. It will be stated preceding the entry for organization (par 42a).

5. The entry for the following item has not been reported as of the date of initial admission as is required. Subsequent changes during the continuous case will not be permitted to modify the entry for this item.

   a. Grade (par 41)
   b. Arm or service (par 42c)
   c. Organization (par 42c)
   d. Age (par 43)
   e. Length of service (par 46a).

6. The following combination of items contains entries which are inconsistent with one another.

a. Length of service is inconsistent with age.
b. Army serial number is inconsistent with grade.
c. Dates of admission and disposition are inconsistent with days lost.
d. Date of injury is inconsistent with the date of admission.

7. The entry for the following item has not been properly recorded.

a. Length of service (par 46a)
b. Date of admission (par 47)
c. Date and place of initial (original) admission (pars 20 & 49c(1))

8. The entry for source of admission has not been properly recorded.

a. Direct admission has been improperly reported as "Command" (par 49b(1)).
b. Case carded for record only has not been properly so identified (par 50).
c. Name and location of proper station has not been shown for direct-casual admission (par 49b(1)).
d. Case admitted as direct-casual from leave, furlough or AWOL (except from a medical installation where a patient) has not been properly recorded (par 49b(2)).
e. Direct admission from AWOL has been improperly recorded as "Readmission from AWOL" (par 49b(2))
f. Case admitted from sick leave, convalescent furlough or AWOL from a medical installation on whose register patient is still carried and to which he is to return, has not been properly recorded as transfer case (par 49c(2)).
g. Case lacking necessary earlier individual medical records serving as transfer cards, fails to show required statement of date and place of initial admission (par 49c(1)) along with statement, "Transfer cards requested but not received".

9. Entry for cause of admission and additional diagnoses has not been properly recorded, as indicated below.

a. In case of transfer, the repeating and numbering of diagnoses has not been properly recorded. In such cases, the receiving medical installation will review all diagnoses recorded on the individual medical records of the transferring medical installations. It will then repeat on its own individual medical record all previous diagnoses except those of terminated conditions and diagnoses previously not concurred in. The numbers originally assigned to these diagnoses will remain unchanged. The diagnoses will be arranged in their original consecutive order but leaving out the numbers of previously terminated conditions and previously "not concurred-in" diagnoses. Thus, for instance, if out of the recorded Dgs 1, 2, 3, 4, and 5, Dg 2 was shown as terminated and

Dg 4 was previously not concurred in, only Dgs 1, 3, and 5 will be repeated. The receiving medical installation will also determine those conditions which, although not shown as cured or not concurred in, are not found to be present at the time of transfer, carefully distinguishing between ones not found because the condition had already terminated and ones not found because the condition, though present, was incorrectly diagnosed. In the former instance, the receiving installation will record only the diagnosis number of the terminated condition, accompanied by the statement "cured", "healed", "arrested", or "recovered from", whichever is applicable (e.g., "Dg 3 cured on admission"). In the latter instance, the receiving installation will record only the diagnosis number of the misdiagnosed condition followed by the statement "not concurred in" and a reference to the replacing diagnosis or diagnoses (e.g., "Dg 3 not concurred in; replaced by Dg 6") (par 4, TB MED 203).

b. A condition or sequela of a condition which has been previously reported on a completed case prior to the present continuous period of illness, has not been properly recorded as "old" and has not been accompanied by the previous diagnosis, date of admission, register number, and name and location of the medical installation where previously recorded (par 11, TB MED 203).

c. Diagnosis improperly recorded "old" on transfer case which has been previously recorded only during the current continuous case. A case which is "new" on initial admission will retain that classification until final disposition of the case, regardless of the number of times the patient may be transferred during the current continuous period of illness (par 11b, TB MED 203).

d. Diagnosis of previous injury or disease (one earlier than the current case) is recorded instead of the residuals which caused the present admission (par 16, TB MED 203).

e. Diagnosis of residuals of old injury fails to specify nature of former injury and of its occurrence (par 16, TB MED 203).

f. Diagnosis of condition specified as "traumatic" has not been accompanied by diagnosis of the specific injury (par 22b(1)), TB MED 203).

g. Diagnosis of injury has not been fully recorded as to how, when, where, circumstances surrounding the event, and the causative agent (par 22b(2), TB MED 203).

h. Disease or condition has been improperly designated only as "venereal", with no diagnosis of the specific venereal disease (par 19e, TB MED 203).

i. Diagnosis of gonorrhea has omitted required information on organs or parts affected, acute or chronic, or "new" or "old". Diagnoses such as "new" gonorrhea, acute, or gonorrhea, chronic "old"....etc., are not complete without statements of the particular parts affected (e.g., urethra, prostate, etc.) (par 21, TB MED 203).

j. Diagnosis has been incompletely recorded, since certain required qualifying terms have not been shown (par 20, TB MED 203).

k. Diagnosis for condition which became terminated before final disposition was not properly so recorded (par 7, TB MED 203).

l. Date of termination has not been recorded for a condition which became healed or cured prior to final disposition (par 7, TB MED 203).

m. Diagnosis has been recorded but has not been assigned a number (par 3b, TB MED 203).

n. An operation has been performed but the diagnosis for the condition requiring operation has not been recorded (par 16, TB MED 203).

o. A condition included on the list of acceptable medical terms (par 21, TB MED 203), has been recorded as a manifestation of a deformity rather than a separate diagnosis.

p. In a case completed by separation from the service for disability the exact nature of the condition necessitating the separation has not been shown. The specific condition, such as ankylosis, contracture, limitation of motion, malunion of fracture, etc., should be reported as a diagnosis rather than vague conditions such as "deformity" or "residuals of injury" (par 10, TB MED 203).

q. In a case terminated by death, neither the autopsy results nor a statement "no autopsy performed" has been recorded (par 53e).

r. Psychiatric diagnosis has not been recorded properly in that the generic disorder terms such as psychonerosis or psychosis should not be recorded. Only the type of reaction (anxiety reaction, conversion reaction, etc.), along with the severity, the chronicity, and when desired, outstanding symptoms, will be reported on WD AGO Form 8-24 (par 18a(1), TB MED 203).

s. Terms have been recorded, such as "inaptness" and "inadaptability", which are not acceptable as diagnoses. Some such cases may represent administrative separations from the service for other than medical conditions - for example, for language deficiency. Where there is no medical basis for the inaptness, it should not be reported as a diagnosis, and cases separated administratively for such reasons should not be carded for record only. Other such cases should be diagnosed as having a specific psychiatric condition which produces the inaptness - for example, mental deficiency, or some behavior disorder such as anti-social personality reaction or emotional instability reaction. Where such a medical condition is present, it should be recorded as the specific condition. In no cases will "inaptness", "inadaptability", or similar expressions be recorded as diagnoses.

t. Requirements for use of definite and acceptable diagnostic terminology have not been met. Manifestations, symptoms, or vague and ill-defined conditions should not be recorded as diagnoses. Preferably diagnoses should be reported in the appropriate terminology as listed in paragraph 21, TB MED 203. When necessary, standard terminology as given in the "Standard Nomenclature of Disease and Standard Nomenclature of Operations" published by the American Medical Association may be used.

u. When a condition necessitating admission is so ill-defined as not to permit a definite diagnosis, the case should be recorded as "undiagnosed condition...", specifying the important manifestations (par 8c, TB MED 203).

v. When it is determined that no disease has been present, in a case which has been under observation for possible disease, the correct

entry will be "no disease: observation for___, not found" (specifying the condition for which patient was under observation) When a patient who has been under observation for possible disease is actually determined to have some condition of ill-health, the diagnosis will be based on that condition and so will be, either a specific disease, or in exceptional cases not definitely diagnosed, an "undiagnosed condition, . . .etc. "as provided in "u" above (par 8a, TB MED 203).

w. Initial and/or final date of leave, pass, AWOL or furlough has not been recorded (par 61).

x. When previous individual medical records in the case are not received, it is requested that conditions "healed on admission" or "not concurred in" by your installation be repeated.

10. The entry for type of specialized treatment given patient is not in accordance with the types established (SGO Circular 45, 1946).

11. The required notations as to any changes in the place of treatment have not been recorded. Movements such as ones from hospital to quarters, or hospital to convalescent facilities, must be recorded (par 60, C2).

12. Separate entry as to line of duty for each of the diagnoses recorded has not been shown (par 12, TB MED 203).

13. The entry for disposition has been improperly recorded as follows:

a. The entry "Duty", has not been qualified as to whether limited or general service (par 66c (1)).

b. The disposition of a case carded for record only has not been recorded in compliance with par 67.

c. The entry in a case disposed of by separation from the service for medical reasons has failed to properly specify the diagnoses causing the separation. This is required for every separation for medical reasons, whether the individual is discharged for disability (CDD), retired or returned to inactive status for disability, or separated under the provisions of AR 615-368 or 615-369 for medical conditions present. This should be done by means of a reference to the number of the diagnosis or diagnoses causing separation. Where more than one diagnosis caused separation, the one principally responsible should be designated, thus: "Retired for disability due to Dg 3, principal cause, and Dgs 2 and 4." (par 66e).

d. The entry in a case terminated by death has failed to properly designate the diagnosis causing the death. This is required for every case, whether cause of death was a diagnosis originally assigned or one added as a result of autopsy findings. In every case, this designation will be accompanied by a reference in the space for disposition to the diagnosis number of the cause or causes of death, thus: "Death due to Dg 3, primary cause, and Dgs 1 and 4, contributing cause" (par 66d).

14. The entry for date of disposition has not been properly recorded (par 68).

15. The entry for days lost has been improperly computed. Day of admission should be counted as a day lost, while day of disposition will not be counted (par 69).

16. The entry for designation of reporting installation has not been recorded correctly in that the entry fails to indicate the type of installation, (dispensary, station hospital, etc.), and/or geographical location (par 70).

17. The initial medical installation will use the front of the EMT (par 151). Inasmuch as the patient was not transferred to another medical installation, the final disposition and date of disposition should be recorded in the space "Disposition" and "Date" respectively.